Canadian Family Physician

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Information for Authors
CANADIAN FAMILY PHYSICIAN is distributed to all family physicians, non-certified specialists, family practice residents and some final year medical students in Canada—a circulation of approximately 19,000. Articles on clinical, academic, research, philosophical, political or business topics of direct relevance to the practicing family physician are welcomed. Letters to the editor are also welcomed; they should be brief and should contain precise references to quoted material. CANADIAN FAMILY PHYSICIAN is listed in *Current Contents/Clinical Practice* and *FAMLI*.

Manuscripts
Material for publication is reviewed by an editorial advisory board of practicing family physicians. Manuscripts should be sent to the editor at 4000 Leslie St., Willowdale, ON., with a covering letter. CANADIAN FAMILY PHYSICIAN accepts only original material which is not under consideration by any other publication and which may not be reprinted without the consent of both the author and the editor. The editor reserves the right to edit manuscripts for length, clarity and conformity with the journal's style.

Articles should be typed double spaced and the author should retain one copy, sending three to the editor. American spelling should be used, and measurements must be given in correct metric abbreviations, e.g. mg = milligram(s), cm = centimeter(s). Drugs should be referred to generically, with the usual trade name following in brackets. Articles may be submitted in English or French. A title page should be submitted with the article, listing the title, authors' names, their current positions, an address for reprints and a 100 word summary. Do NOT send first drafts.

Illustrations and Tables
All illustrations and tables should be included separately from the manuscript and should be clearly identified in Arabic numerals, showing which is the top of the illustration if this is not obvious. Legends for illustrations (which should be referred to as 'Figures') should be typed separately. Tables must supplement the text without duplicating it. They should be numbered in Arabic numerals and should include an appropriate title.

Illustrations should be either black and white glossy photographs or India ink drawings. Unless previously agreed with the editor, color illustrations can be published only at the author's expense.

References
References should be numbered according to their appearance in the text and should be limited to work cited in the article, rather than a bibliography of the subject. Personal communications are not acceptable as references; unpublished material should be included only if an address can be given from which a copy is available.

Authors are responsible for accuracy of references, which should be in keeping with the Uniform Requirements for Manuscripts Submitted to Biomedical Journals.

Proofs and Reprints
Galley proofs of the edited article will be sent to the author and should be returned within three days. Major changes cannot be made on galley proofs; proofreading should therefore be for accuracy only.

Authors will receive 50 reprints of their articles plus an order form and price list for further reprints.

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Cover: The discipline of family medicine encompasses a continuum of care—from birth to old age. Meghan, firstborn daughter of CFP's editor Margaret McCaffery, is held by senior citizen Gabriel Kostelnyk. Photography by Barry E. Neubauer. Design by Bill Woods.

PAAB CCPP

ccab AMM

NOTE: All prescription drug advertisements in CFP have been precleared by the Pharmaceutical Advertising Advisory Board.

Capsules

The family medicine literature is wide and varied—and not all to be found in Index Medicus. On this page, our librarian Lynn Dunikowski provides synopses of articles from the current literature, full texts of which can be obtained from the Canadian Library of Family Medicine, Sciences Library, Natural Sciences Centre, University of Western Ontario, London, ON. N6A 5B7. Alternatively, local medical libraries or hospital libraries may be able to help.

Breast Feeding

Wright JH, Walker PC: Prediction of duration of breast feeding in primiparas. J Epidemiol Community Health 1983; 37:89-94.

A random sample of 617 primiparas was identified from birth notifications over a 12 month period; 534 of these were interviewed four weeks after confinement. Those breast-feeding at the time of the interview were contacted again at four months and those still breast-feeding then were contacted at 6.5 months.

Duration of breast-feeding was found to be significantly associated with five associated personal characteristics of the mother and with specific aspects of her knowledge and attitudes about breast-feeding. In hospital, the timing of the first breast-feed and difficulties with subsequent feeds were important indicators. At home, the use of additional formula feeds was associated with a reduced prevalence of breast-feeding by 18 weeks. A combination of older maternal age at confinement and older age at leaving school contributed to a ten-fold increase of prevalence rates in breast-feeding at 16 weeks between groups of mothers. These two factors alone may help doctors, midwives, and health visitors in assessing the risk of premature termination of breast-feeding and in planning programs of preventive care.

Calcium Channel Blockers

Frishman WH, Charlap S: Verapamil in treatment of chronic stable angina. Arch Intern Med 1983; 143:1407-1415.

Verapamil, a calcium-entry blocking drug, is now available for the treatment of chronic stable angina. The effectiveness of the drug in obstructive coronary disease depends on a complex interplay of its direct actions and the reflex phenomena that they elicit. Clinical trials demonstrate that the efficacy and safety of verapamil in treating patients with effort-related angina compares favorably with that seen with other antianginal agents. Relative contraindications to the use of verapamil include left ventricular dysfunction and sinus node and atrioventricular conduction disease. Combination therapy of beta-blockers with verapamil can benefit many patients, but also has the potential for serious adverse reactions. Careful selection of patients for such therapy is therefore necessary. Verapamil is proving to be an important addition to existing drug regimens for the treatment of stable angina pectoris.

Smith RD: Calcium entry blockers: Key issues. Fed Proc 1983; 42:201-206

Calcium entry blockers (CEBs) are of interest due to the primary role of CA^{2+} in excitation-contraction coupling in vascular smooth muscle and the probable involvement of CA^{2+} in the etiology of hypertension. The role of CEBs in the management of chronic essential hypertension, however, has not been established. Key issues are the definition of CEBs, mechanism of vasodilator action(s), tissue selectivity, quality of antihypertensive effects, other effects, and future developments. CEBs may have multiple intracellular and extracellular sites of action and may modify both energy production and excitation-contraction coupling in vascular smooth muscle.

CEBs are not unique in their vasodilator-antihypertensive profile. However, their other effects such as coronary vasodilator or cardioprotective effects and their tissue selectivity may provide a favorable risk/benefit ratio for their chronic use in essential hypertension.

New CEBs may be called modifiers of calcium metabolism, may actually be curative in hypertension, and will most certainly be of major physiological and pharmacological interest.

Diagnostic Testing

Williams SV, Eisenberg JM, Pascale LA, et al: Physicians' perceptions about unnecessary diagnostic testing. Inquiry 1982; 19:363-370.

Clinical laboratory testing cost about $11 billion in 1977, which constituted approximately 6% of all expenditures for health care that year. In the mid-1970s the cost of hospital laboratory testing increased at an annual rate of 13.8%, which was greater than the increase in total health care costs for the same period. Radiologic testing cost about $6.3 billion in 1978, which constituted 4% of that year's health expenditures. Between 1970 and 1978, the cost of radiologic examinations increased at an annual rate of 13.7%. Some observers contend that the collective costs of these laboratory tests and radiologic procedures account for more of the increase in overall health care costs than do low-volume but expensive technologies such as computerized tomographic scanning.

One reason for the increased cost of diagnostic testing is that increasing numbers of tests are being performed.

There would be less concern over the increasing cost of diagnostic testing if the use of more tests were producing more health. Careful studies of patients with pulmonary edema and acute myocardial infarction, however, do not show better outcomes when more diagnostic tests are used. Several studies suggest that in many clinical situations, clinicians can exercise broad discretion in the use of diagnostic tests without affecting patient outcome.

FEBRUARY

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Send all information on courses to Calendar, 4000 Leslie St., Willowdale, ON. M2K 2R9, at least three months before the date of the course. Readers wishing to register or get further information on courses should write to the address listed under 'Information', and NOT to CANADIAN FAMILY PHYSICIAN.

Approved Courses

2 Balint Seminar for Family Physicians. Outremont, PQ. Information: Dr. Jean-Pierre Bienvenu, 40 Querbes Ave., Apt. 6, Outremont, PQ. H2V 3V6 (1½ hours)

2 Thursday Evening Lectures Series. McGill University, Montreal, PQ. Information: Drs. D. Danoff, G. Fraser and F. Lehmann, CME, McGill University, 1110 Pine Ave. West, Montreal, PQ. H3A 1A3 (2 hours)

2-4 Advanced Trauma Life Support Provider Course. Sunnybrook Medical Centre, Toronto, ON. Information: Dr. S. Kandel, Sunnybrook Medical Centre, 2075 Bayview Ave., Toronto, ON. M4N 3M5

3 Occupational Medicine: Risk Perception. Academy of Medicine, Toronto, ON. Information: Occupational Health Section, Academy of Medicine, 288 Bloor St. West, Toronto, ON.

3-5 Advanced Cardiac Life Support Course. Sunnybrook Medical Centre, Toronto, ON. Information: Dr. S. Kandel, Sunnybrook Medical Centre, 2075 Bayview Ave., Toronto, ON. M4N 3M5

3-5 Advanced Trauma Life Support Course. Halifax, NS. Information: Short Course Program Coordinator, CME, Sir Charles Tupper Medical Building, Dalhousie University, Halifax, NS. B3H 4H7

4 Saturday Morning CME Program. Prince Edward County Memorial Hospital, Picton, ON. Information: Dr. Norah Connell, R.R. #1, Picton, ON. K0K 2T0 (1½ hours)

5-Mar 1 Phase I Program: Experiential Month. Quadra Island, BC. Information: Dr. J. McKeen, PD Seminars, Davis Rd., Gabriola Island, BC. V0R 1X0

6 Seminars in Family Medicine. Doctors Hospital, Toronto, ON. Information: Dr. M. Soboloff, 895 Bloor St. West, Toronto, ON. (1 hour)

9 Advances in Cancer Chemotherapy. Roswell Park Memorial Institute, Buffalo, NY. Information: Gayle Bersani, RN, Cancer Control Coordinator, Roswell Park Memorial Institute, 666 Elm St., Buffalo, NY. 14263, U.S.A.

9 Balint Seminar for Family Physicians. Outremont, PQ. Information: Dr. Jean-Pierre Bienvenu, 40 Querbes Ave., Apt. 6, Outremont, PQ. H2V 3V6 (1½ hours)

9 Thursday Evening Lectures Series. McGill University, Montreal, PQ. Information: Drs. D. Danoff, G. Fraser and F. Lehmann, CME, McGill University, 1110 Pine Ave. West, Montreal, PQ. H3A 1A3 (2 hours)

9-10 Belief and Healing II: Pain and Human Suffering. McMaster University, Hamilton, ON. Information: Mrs. B. Woods, CME, Room 1M6, McMaster University HSC, 1200 Main St. W., Hamilton, ON. L8S 4J9

9-10 Update '84 for Family Physicians. Toronto General Hospital, Toronto, ON. Information: Dr. M. Gutman, Toronto General Hospital, 101 College St., Toronto, ON. M5G 1L7 (12 hours)

10 Afflictions of the Feet. Winnipeg, MB. Information: Dr. J. C. Menzies, Director, CME, Department of Family Medicine, S-100 Medical Services Building, 750 Bannatyne Ave., Winnipeg, MB. R3E 0W3 (5 hours)

10-11 C. G. Jung Foundation Program: The Addictive Personality. Academy of Medicine, Toronto, ON. Information: Dr. C. Conway Smith, 562 Eglinton Ave. East, Toronto, ON. M4P 1P2 (7 hours)

11 Saturday Morning CME Program. Prince Edward County Memorial Hospital, Picton, ON. Information: Dr. Norah Connell, R.R. #1, Picton, ON. K0K 2T0 (1½ hours)

12-17 Prevention, Diagnosis and Treatment of Communicable Disease in the Traveller. Galeria Plaza Hotel, Mexico City, Mexico. Information: Dr. W. A. Black, Director, Division of Laboratories, 828 West 10th Ave., Vancouver, BC. V6J 4M3 (23 hours)

13 Seminars in Family Medicine. Doctors Hospital, Toronto, ON. Information: Dr. M. Soboloff, 895 Bloor St. West, Toronto, ON. (1 hour)

15 Queen's University Monthly CME Meeting. Hotel Dieu Hospital, Kingston, ON. Information: Dr. C. A. Johnson, Queen's University, 220 Bagot St., Kingston, ON. K7L 5E9 (1 hour)

16 Balint Seminar for Family Physicians. Outremont, PQ. Information: Dr. Jean-Pierre Bienvenu, 40 Querbes Ave., Apt. 6, Outremont, PQ. H2V 3V6 (1½ hours)

16 Thursday Evening Lectures Series. McGill University, Montreal, PQ. Information: Drs. D. Danoff, G. Fraser and F. Lehmann, CME, McGill University, 1110 Pine Ave. West, Montreal, PQ. H3A 1A3 (2 hours)

18 Saturday Morning CME Program. Prince Edward County Memorial Hospital, Picton, ON. Information: Dr. Norah Connell, R.R. #1, Picton, ON. K0K 2T0 (1½ hours)

20 Seminars in Family Medicine. Doctors Hospital, Toronto, ON. Information: Dr. M. Soboloff, 895 Bloor St. West, Toronto, ON. (1 hour)

22-25 Fifth Annual Winter Symposium: Grand Rounds in Medicine. Mariott Hotel, Ft. Lauderdale, FL. Information: Mrs. B. Woods, CME, Room 1M6, McMaster University HSC, 1200 Main St. W., Hamilton, ON. L8S 4J9

22-25 Pediatrics, Obstetrics and Gynecology. Regina, SK. Information: Dr. A. W. Juckes, CME, Regina General Hospital, Regina, SK. S4P 0W5

23 Balint Seminar for Family Physicians. Outremont, PQ. Information: Dr. Jean-Pierre Bienvenu, 40 Querbes Ave., Apt. 6, Outremont, PQ. H2V 3V6 (1½ hours)

23 Thursday Evening Lectures Series. McGill University, Montreal, PQ. Information: Drs. D. Danoff, G. Fraser and F. Lehmann, CME, McGill University, 1110 Pine Ave. West, Montreal, PQ. H3A 1A3 (2 hours)

23-25 Advanced Trauma Life Support Provider Course. Sunnybrook Medical Centre, Toronto, ON. Information: Dr. S. Kandel, Sunnybrook Medical Centre, 2075 Bayview Ave., Toronto, ON. M4N 3M5

23-25 Tenth Annual Spring Refresher. Halifax, NS. Information: Short Course Program Coordinator, CME, Sir Charles Tupper Medical Building, Dalhousie University, Halifax, NS. B3H 4H7

24 Emergency Department Didactic Rounds. Scarborough General Hospital, Scarborough, ON. Information: Dr. I. Feferman, Director, Emergency Services, Scarborough General Hospital, 3050 Lawrence Ave. East, Scarborough, ON. M1P 2V5 (1 hour)

24-26 Advanced Cardiac Life Support Course. Sunnybrook Medical Centre, Toronto, ON. Information: Dr. S. Kandel, Sunnybrook Medical Centre, 2075 Bayview Ave., Toronto, ON. M4N 3M5

25 Saturday Morning CME Program. Prince Edward County Memorial Hospital, Picton, ON. Information: Dr. Norah Connell, R.R. #1, Picton, ON. K0K 2T0 (1½ hours)

25-26, Mar 10-11 Life Style Diagnosis. Ontario Institute for Studies in Education, Toronto, ON. Information: Evelyn Piltch, Alfred Adler Institute of Ontario, 4 Finch Ave. West, Suite 10, Willowdale, ON. M2N 2G5 (22 hours)

26-March 2 Alberta Chapter of the College of Family Physicians of Canada 29th Annual Scientific Assembly. Banff Park Lodge, Banff, AB. Information: Ms. Elaine Taschuk, P.O. Box 3846, Station D, Edmonton, AB. T5L 4K1

27 Seminars in Family Medicine. Doctors Hospital, Toronto, ON. Information: Dr. M. Soboloff, 895 Bloor St. West, Toronto, ON. (1 hour)

27-28 Parent/Child Health Conference: Combined Care and Infertility Program. Park Plaza Hotel, Toronto, ON. Information: Ingrid Norrish, P.O. Box 1900, Rexdale, ON. M9W 5L7 (12 hours)

29 Cancer Symposium. Victoria Hospital, London, ON. Information: Dianne McCormack, CME, Faculty of Medicine, University of Western Ontario, London, ON. N6A 5C1

Other Courses

1-2 Liability for Hospitals and Professional Staff. Don Mills, ON. Information: S. Denault, Managing Director, The Canadian Institute of Law and Medicine, P.O. Box 1015, King City, ON. L0G 1K0

1-3 The 1984 Sandoz Lectures in Gerontology. Basle, Switzerland. Information: The 1984 Sandoz Lectures in Gerontology, Sandoz Canada Inc., 385 Bouchard Blvd., Dorval, PQ. H9R 4P5

6-8 The Use of Diagnostic Ultrasound Imaging in Pregnancy. National Institutes of Health, Bethesda, MD. Information: James G. Hill, Chief, Office of Planning and Evaluation, National Institute of Child Health and Human Development, National Institute of Health, Building 31, Room 2A10, Bethesda, MD. 20205, U.S.A.

8 Riverdale Hospital Annual Clinical Day. The Riverdale Hospital, Toronto, ON. Information: Dr. E. A. Robinson, Chairman, Ongoing Education Committee, The Riverdale Hospital, 14 St. Matthews Rd., Toronto, ON. M4M 2B5

8 Clinical Day: Gyne-urological Problems. Royal Victoria Hospital, Montreal, PQ. Information: Centre for Continuing Medical Education, McGill University, 1110 Pine Ave. West, Montreal, PQ. H3A 1A3

10-11 British Columbia Heart Foundation 1984 Cardiac Symposium: As Time Goes By. Hyatt Regency Hotel, Vancouver, BC. Information: Dr. Victor Huckell, Vancouver General Hospital, 316-2775 Heather St., Vancouver, BC. V5Z 3J5

13-17 Emergency Medicine Series: Medical and Non-Traumatic Surgical Emergencies. Towsley Center, Ann Arbor, MI. Information: Office of Continuing Medical Education, Towsley Center, Box 057, University of Michigan Medical School, Ann Arbor, MI. 48109, U.S.A.

15 Day in Family Medicine. Henderson General Hospital, Hamilton, ON. Information: Medical Staff Secretary, Henderson General Hospital, 711 Concession St., Hamilton, ON. L8V 1C3

18-24 Third Annual Canadian Winter Anesthesia Meeting. Banff Springs Hotel, Banff, AB. Information: Dr. David A. Pelton, Department of Anesthesia, The Hospital for Sick Children, 555 University Ave., Toronto, ON. M5G 1X8

19-26 World Federation of Public Health Associations. Tel-Aviv, Israel. Information: Israel Government Tourist Office, 180 Bloor St. West, Suite 700, Toronto, ON. M5S 2V6

20-25 Conference on the Beach: Fifth Annual Family Practice Update. Daytona Beach, FL. Information: Ken

Mead, Conference Coordinator, P.O. Box 9054, Daytona Beach, FL. 32020, U.S.A.

23-26 Eleventh Pediatric Dermatology Seminar. Doral on the Beach Hotel, Miami Beach. FL. Information: Dr. Guinter Kahn, Program Director, 16800 NW 2nd Avenue, #401, N. Miami Beach, FL. 33169, U.S.A.

MARCH

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Approved Courses

1 Thursday Evening Lectures Series. McGill University, Montreal, PQ. Information: Drs. D. Danoff, G. Fraser and F. Lehmann, CME, McGill University, 1110 Pine Ave. West, Montreal, PQ. H3A 1A3 (2 hours)

8 Thursday Evening Lectures Series. McGill University, Montreal, PQ. Information: Drs. D. Danoff, G. Fraser and F. Lehmann, CME, McGill University, 1110 Pine Ave. West, Montreal, PQ. H3A 1A3 (2 hours)

15 Thursday Evening Lectures Series. McGill University, Montreal, PQ. Information: Drs. D. Danoff, G. Fraser and F. Lehmann, CME, McGill University, 1110 Pine Ave. West, Montreal, PQ. H3A 1A3 (2 hours)

19-23 Eighth Annual Family Practice Review. Lancaster, PA. Information: Dr. Albert J. Finestone, Associate Dean for CME, Temple University School of Medicine, 3400 North Broad St., Philadelphia, PA. 19140, U.S.A. (50 hours)

22 Thursday Evening Lectures Series. McGill University, Montreal, PQ. Information: Drs. D. Danoff, G. Fraser and F. Lehmann, CME, McGill University, 1110 Pine Ave. West, Montreal, PQ. H3A 1A3 (2 hours)

22-24 Annual Meeting: Western Division of the Canadian Anesthetists' Society. Edmonton, AB. Information: Dr. R. G. Johnston, Room 4228, Royal Alexandra Hospital, 10240 Kingsway, Edmonton, AB. T5H 3V9 (15 hours)

28 Winchester District Memorial Hospital Education Day. Winchester, ON. Information: Dr. C. R. S. Dawes, Education Committee, Winchester District Memorial Hospital, Memorial Drive, Winchester, ON. K0C 2K0 (3 hours)

29 Thursday Evening Lectures Series. McGill University, Montreal, PQ. Information: Drs. D. Danoff, G. Fraser and F. Lehmann, CME, McGill University, 1110 Pine Ave. West, Montreal, PQ. H3A 1A3 (2 hours)

APRIL

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Approved Courses

2-5 Scientific Assembly of the Canadian Association of Emergency Physicians. Hyatt Regency Hotel, Vancouver, BC. Information: Dr. S. Glazer, 3420 West 15th Ave., Vancouver, BC. (18 hours)

5 Thursday Evening Lectures Series. McGill University, Montreal, PQ. Information: Drs. D. Danoff, G. Fraser and F. Lehmann, CME, McGill University, 1110 Pine Ave. West, Montreal, PQ. H3A 1A3 (2 hours)

12 Thursday Evening Lectures Series. McGill University, Montreal, PQ. Information: Drs. D. Danoff, G. Fraser and F. Lehmann, CME, McGill University, 1110 Pine Ave. West, Montreal, PQ. H3A 1A3 (2 hours)

27-28 1984 Spring Seminar: Keeping the Elderly Healthy and at Home. Ramada Inn, Toronto, ON. Information: Mrs. Marcia Barrett, Administrative Director, Ontario Chapter, The College of Family Physicians of Canada, 4000 Leslie St., Willowdale, ON. M2K 2R9 (11½ hours)

Other Courses

5-6 The Nurse Practitioners' Association of Ontario 11th Annual Spring Conference. Toronto, ON. Information: K. Mowat, The Nurse Practitioners' Association of Ontario, c/o 70 Grenview Blvd. South, Toronto, ON. M8Y 3S4

MAY

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Approved Courses

2-5 North American Primary Care Research Group 12th Annual Meeting—Research in a Brave New World: Community-Oriented Primary Care. Orlando, FL. Information: NAPCRG 1984, Department of Family Medicine, University of Miami, P.O. Box 016700, Miami, FL. 33101, U.S.A.

30 Winchester District Memorial Hospital Education Day. Winchester, ON. Information: Dr. C. R. S. Dawes, Education Committee, Winchester District Memorial Hospital, Memorial Drive, Winchester, ON. K0C 2K0 (3 hours)

Other Courses

5-9 Society of Teachers of Family Medicine 17th Annual Spring Conference. Orlando, FL. Information: STFM 1984, Department of Family Medicine, University of Miami, P.O. Box 016700, Miami, FL. 33101, U.S.A.

13-16 Eighth Annual Conference of the Canadian Organization for Advancement of Computers in Health. Hotel Nova Scotian, Halifax, NS. Information: The Canadian Organization for Advancement of Computers in Health, 10504A-169 Street, Edmonton, AB. T5P 3X6

JUNE

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Approved Courses

16-23 British Columbia Chapter of The College of Family Physicians of Canada 25th Annual Scientific Session: Family in Distress. Island Princess Cruise Ship, Vancouver to Alaska, return. Information: Dr. J. B. McInnis, 214-1046 Austin Ave., Coquitlam, BC. V3K 3P3

Other Courses

25-28 Canadian Health Kaleidoscope: Canadian Public Health Association 75th Annual Conference. Calgary, AB. Information: Canadian Public Health Association, Suite 210, 1335 Carling Ave., Ottawa, ON. K1Z 8N8

JULY

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1	2	3	4	5	6	7
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Approved Courses

8-11 CFPC 26th Annual Scientific Assembly: The Art and Science of Family Medicine. Hyatt Regency Hotel, Vancouver, BC. Information: Mr. D. J. C. Steen, Director of Administration, The College of Family Physicians of Canada, 4000 Leslie St., Willowdale, ON. M2K 2R9

acupuncture, visual imagery, orthomolecular medicine, megavitamin therapy, etc.) are already under scrutiny. Many deserve early dispatch; others will undergo slow attrition. Some could eventually be developed as effective elements of everyday practice. It is an exciting challenge and opportunity for family medicine as a discipline to assist in establishing the validity of potentially useful new methods of health care.

Within our university department of family practice, we foresee the eventual establishment of a division of behavioral medicine. Its activities should be founded firmly on the provision of service[13] (e.g., sponsorship of smoking cessation, weight control, sleep, pain and stress management programs). Basic and clinical research, built on this service component, could advance the scientific validity of various new modalities and teaching methods for undergraduates, residents and practicing health professionals.[14] Larger medical communities already contain respected practicing primary care physicians who have relevant knowledge and skills in nutrition, biofeedback, behavior modification, lifestyle counselling, hypnosis, exercise prescription, human sexuality, meditation and autogenic training. They, along with interested academic family practice faculty and clinicians from a number of other disciplines, such as health psychology, education, social work, medical anthropology and epidemiology, can be expected to take the lead in developing behavioral medicine as a part of modern Canadian health care. It arises naturally out of their daily work, provides opportunity for professional growth and falls more comfortably within their areas of experience, expertise and competence than those of any other health professionals. ◉

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6. Kopelman L, Moskop J: The holistic health movement: A survey and critique. J Med Philos 1981; 6:209-230.

7. Gillette RD: Holistic medicine, wellness and family medicine. J Fam Pract 1980; 10:1093.

8. McKeen J, Wong B: The doctor-patient relationship: Current challenges. BC Med J 1981; 23:370-372.

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11. Steinert Y, Golden M, Klein M: Teaching the behavioral sciences in family medicine. Can Fam Physician 1981; 27:807-811.

12. Schwenk T: Family practice and the behavioural sciences: The need for technology. Fam Med 1982; 14:17-20.

13. Grantham P: Setting goals for family practice departments. Can Fam Physician 1982; 28:791-794.

14. Cassidy RC, Swee B, Stuart M, et al: Teaching biopsycho-ethical medicine in a family practice clerkship. J Med Educ 1983; 58:778-783.

The College of Family Physicians of Canada

CONDITIONS OF ELIGIBILITY FOR MEMBERSHIP

ACTIVE MEMBER—$185

(a) **Active members in this College shall be duly elected members whose status has been confirmed by the Executive Director, and whose dues to this College have been paid.**

(b) The requirements for active membership shall be:

i. To be engaged in active family practice or to qualify for certification as a residency-eligible candidate.
ii. To have conducted practice according to the Code of Ethics of the College.
iii. To undertake to complete fifty (50) hours of approved postgraduate study during each one (1) year period.

(c) Active members shall be elected initially for a probationary period of one year. Thereafter they shall be eligible for re-election for two-year periods if so recommended by the Credentials Committee after a review of the postgraduate studies completed in the previous requisite period. No member shall be re-elected to membership who has not completed during the preceding two (2) year period a minimum of one hundred (100) hours of postgraduate study of a nature acceptable to the Board of Directors.

CERTIFICANT MEMBER

(a) Certification shall be granted to eligible candidates following the satisfactory completion of an appropriate examination set by the College.
(b) Certificants shall be entitled to the same privileges, rights, duties and requirements as active members.
(c) Certificants shall be designated "Certificant of the College of Family Physicians of Canada", or abbreviated, "C.C.F.P.".
(d) Active certificants will be required to pay an additional $10 per year for the maintenance of certification program.

ASSOCIATE MEMBER—$20

(a) Associate membership may be granted to any intern or resident in training for family medicine.
(b) Associate members shall be entitled to the floor at general meetings but shall not vote nor hold office.

SUSTAINING MEMBER—$110

(a) Sustaining membership may be granted to any physician who is not engaged in the active practice of medicine, and who has entered another field of endeavor but desires to keep his affiliation or become affiliated with the College.
(b) Sustaining members shall have no postgraduate study requirements.
(c) Sustaining members shall have the privilege of the floor at general meetings, but may not vote nor hold office.

SENIOR MEMBER—$110

(a) Senior membership shall be granted to active members past the age of sixty-five (65), who have been engaged in active family practice more than thirty (30) years.
(b) Senior members shall have no post graduate study requirements.
(c) Senior members shall have the privilege of the floor at general meetings, may vote.and may hold office.

RETIRED MEMBER—No fee

Is a physician who is no longer practicing family medicine on a fulltime or part-time basis and who is no longer engaged in professional activities. The retired member is required to pay the annual membership fee(s) but need not submit evidence of a program of postgraduate studies.

LIFE MEMBER—ACTIVE—No fee

Is a physician who has attained age seventy. The life member who is actively engaged in or concerned with the practice of family medicine is not required to pay the annual membership fee(s) but is required to comply with the other components of the Active membership classification.

LIFE MEMBER—RETIRED—No fee

Is a physician who has attained age seventy. The retired life member is not required to pay the annual membership fee(s) and need not submit evidence of a program of postgraduate studies.

NONRESIDENT—$90

Nonresident membership is granted to members who are resident outside *Canada*. The rights, duties and requirements of Nonresident members are determined by the membership classification to which they belong.

PROVINCIAL CHAPTER FEE is an additional fee set by certain chapters to provide for further activities at the provincial level. Those chapters having a provincial fee include:

ALBERTA	$65
BRITISH COLUMBIA	$40
MANITOBA	$30
NEW BRUNSWICK	$15
NEWFOUNDLAND	$25
SASKATCHEWAN	$30
ONTARIO—Active	$52
—Senior	$47
—Sustaining	$24
—Associate	$24
NOVA SCOTIA	$20
QUEBEC	$15
PRINCE EDWARD ISLAND	$20

The College of Family Physicians of Canada

APPLICATION FOR MEMBERSHIP

(Please print or type)

Name in full .....

Office address ..... City ..... Prov. ..... Postal Code .....

Residence address ..... City ..... Prov. ..... Postal Code .....

Place and date of birth .....

Sex Male ..... Female .....

Medical Education—Medical School .....

Date of graduation ..... Degree .....

Licensed to practice in ..... province(s)

Other qualifications and diplomas .....

.....

.....

Internships—Hospitals ..... Year .....

and/or ..... Year .....

Residencies—Universities ..... Year .....

..... Year .....

Teaching appointments .....

.....

Are you in active family practice? Yes☐ No☐

If "yes", how long have you been engaged as a family physician? .....

If "no", what is your present activity? .....

Are you a member of a hospital staff(s)? Yes☐ No☐

In what category? – Honorary☐ Active☐ Associate☐ Consulting☐ Courtesy☐

Name of hospital(s) .....

.....

Member of ..... medical society

..... medical society

..... medical society

Declaration

I hereby make application for membership in The College of Family Physicians of Canada.
I am enclosing my fees for a 12-month period in the class of Active ☐ Senior ☐ Associate ☐ Sustaining ☐ Retired ☐
Life—Active ☐ Life—Retired ☐ membership, in accordance with present membership fees. See "Conditions of Eligibility for Membership."
I understand that the money will be refunded if my application is not approved.
In submitting this application, I hereby agree to abide by the regulations of The College of Family Physicians of Canada.
References: (Must be members of the College of Family Physicians of Canada).

	NAME	ADDRESS
1.	.....	.....
2.	.....	.....

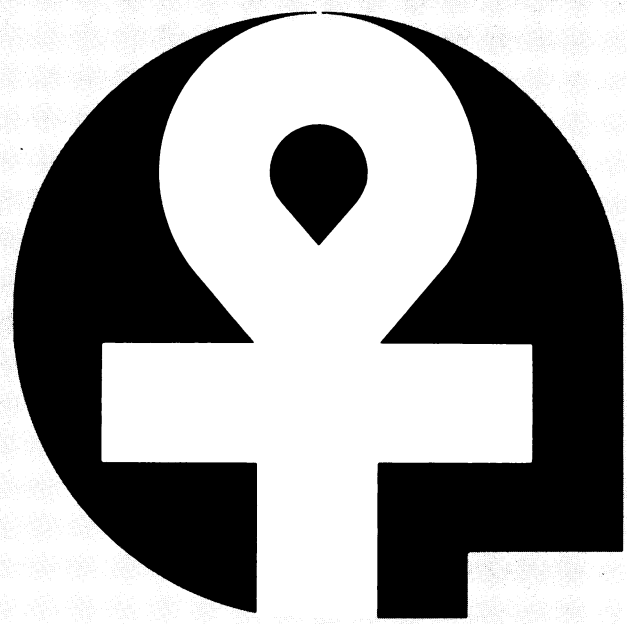
Date .....

..... Signature of Applicant

Membership Certificate: I wish to have my membership certificate in the French language ( ) English language ( )

Membership applications should be sent to:
The College of Family Physicians of Canada
4000 Leslie Street
Willowdale, Ontario M2K 2R9

This application form supersedes all similar forms previous to January 1978



LIFESTYLE

A new section of CFP for readers who want to help healthy patients stay healthy

In this issue:

THIS MONTH

• Death of a Down's syndrome baby • Confidentiality in medicine • Health trends and new illnesses • New mothers' gender preferences • Protecting premature babies against intraventricular hemorrhage • Nifedipine's effects on the menstrual cycle • Investigating rashes in early pregnancy • Preventing childhood poisoning • Perioral dermatitis • Humanism in doctor/patient relationships • Meningitic reaction to intravenous iron dextran • Sensory side effects of sarcoidosis • Infant 'burp' sign • The value of autopsies

Read anything in the overseas medical literature that you think is worth quoting on these pages? Send a copy along to Medical Digest. This column reviews all non-Canadian English language medical journals for items of interest to the Canadian family doctor. Extracts should preferably be not more than one column in length and should be accompanied by the correct Index Medicus reference to the journal.

Death Of Baby Doe

In Bloomington, Indiana, in the spring of 1982, a term male infant with Down's syndrome and a tracheosophageal fistula was born. The parents decided to forgo treatment, and the infant was allowed to die. The medical records were sealed by the court to protect the anonymity of the parents. The "Infant Doe" case has generated enormous local and national attention, with a recent change in the law of the state of Indiana and action at the federal level anticipated. In order to place the often heated and partisan discussions on a factual basis, the medical circumstances are here offered for public scrutiny.

The mother, a 31-year-old para II, gravida III, with two healthy children at home, started her labor six days early. The membranes ruptured spontaneously, revealing polyhydramnios with green-tinged amniotic fluid. Some fetal distress was noted during the two-hour labor, and indeed the infant, delivered spontaneously from the vertex position, was limp and cyanotic, with a heart rate of less than 100 (Apgar 2). The one-minute and five-minute Apgar scores were 5 and 7, respectively. The birth weight was 2722 g, and the length 50.8 cm from crown to heel. The presence of Down's syndrome was readily apparent from the flat nasal bridge, broad epicanthal folds, upward-slanting eyes, and rounded calvarium. A catheter could not be passed into the stomach, suggesting tracheosophageal fistula, and chest X-ray films revealed a somewhat enlarged heart, which—together with decreased pulses in the lower extremities—led to the diagnosis of possible aortic coarctation.

After consideration of all the medical information the parents decided not to authorize surgery. The infant was given phenobarbital (5 mg) and morphine (2.5 mg) as needed for pain and restlessness. The parents visited and held the child frequently until his death six days later.

At autopsy the body weight was 2062 g. The body fat was doughy, and the skin showed poor turgor. The esophagus ended in a blind pouch at the level of the fifth tracheal ring; 5 mm below this, just above the carina, there was a fistulous connection, 3 by 6 mm in cross section, from the trachea into the lower esophagus. There were areas of consolidation in the lungs microscopically accounted for by gastric aspiration and acid digestion. The heart weighed 20 g, with only slight predominance of the left ventricle. The ductus arteriosus was patent, the foramen ovule was closed, and the aorta was unremarkable. The brain weighed 240 g and showed the usual foreshortening of Down's syndrome, with abbreviated frontal lobes and widely separated temporal lobes. The superior temporal gyri on both sides were quite attenuated. This, then, was an infant with obvious Down's syndrome and reparable esophageal atresia and tracheosophageal fistula, who had signs of fetal distress and did not breathe well after birth. The potential for mental function and social integration of this child, as of all infants with Down's syndrome, is unknown.

Pless JE: The story of "Baby Doe". N Engl J Med 1983; 309:664.

Keeping Secrets

(A recent author) calls confidentiality in medicine "a decrepit concept" that is "old, worn-out and useless". It is surely old, and it is badly battered, but it is far from useless.

(The author) makes several statements ex cathedra. For example, he refers to "a physician's legal and moral duty, on occasion, to reveal such confidences to third parties, such as families, employers, public-health authorities, or police authorities". None of these examples is established as valid by his statement, but the inclusion of employers is particularly noteworthy. He might extend his thought to the idea that the patient is the doctor's and hospital's employer. Maybe he would then respect the patient's rights.

It is true that hospital records are now in effect open to everyone. We have failed to defend patients' rights from the massive intrusion by third-

party carriers and their clerks (people who are certainly not motivated by the patient's interest).

It is bad enough that physicians must write charts not simply to help provide the best care but also to avoid giving third-party carriers an excuse for not paying the insurance the patient has purchased. Now we are moving into a period in which we must decide whether writing a diagnosis (as simple as hypertension) will endanger the patient's employability (not because the disease makes him or her a hazard to society but because employers, including municipal governments, want to keep fringe-benefit premiums down).

(The author) defines the purpose of confidentiality well. He recognizes its desirability, but he despairs of defending it in hospitals. Restriction of records on a 'need-to-know' basis is meaningless unless doctors define who needs to know, and at present they do not.

Until we can regain control of our records from administrators, review bodies, and others, it is necessary to go further than the psychiatrists have. They have kept their records separate from the general medical record. This gives only partial protection. Those records too can be obtained. Physicians must learn to keep material they consider sensitive out of the record all together, either in their heads or in private records.

The key to confidentiality is the recognition that the hospital chart is not private, and that the patient has the right to expect us to keep some things out of the record. This is a step we take with regret, but our responsibility as doctors is to our patients, not to the burgeoning bureaucracy. ❞

Deming QB: Confidentiality in medicine. N Engl J Med 1983; 308:1169.

Cyclical Symptoms

❝ Over the past few years, (the) pages of *(The New England Journal of Medicine)* have informed us of a barrage of new illnesses related to jogging. In this vein, it is interesting to note that when bicycling became the rage in this country in the 1890s, a similar spate of new diseases were described in these very same pages. Nearly everyone could and did bicycle, and a new mode of physical conditioning, which has been referred to as "the hygiene of the wheel", began.

From 1891 to the early 1900s, both in Europe and in America, many medical books and journals explored the issue of bicycling-related illnesses. A new medical category—diseases of cycling—developed as physicians' interest shifted from acute injuries related to bicycling to more chronic ailments. 'Kyphosis bicyclistarum' was extensively studied and was more commonly referred to as 'cyclist's figure', 'cyclist's spine', and 'cyclist's stoop'. The possibility of hereditary transmission of this disorder of the spine worried many. Manufacturers were urged to develop a 'health bicycle' that could only be propelled by a person sitting erect. Many appendicitis victims were also bicyclists, and it was proposed that strenuous cycling might twist the appendix over the edge of the contracted psoas major muscle, contuse it, and lead to appendicitis. In similar fashion, it was feared that inguinal hernia might be produced by strenuous peddling; others thought that cycling might cure inguinal hernia.

'Cyclist's sore throat' was said to result from inhalation of cold air, dust, and bacteria through the mouth, causing irritation and inflammation of the bronchial passageways. 'Bicycle face' was characterized by a peculiar strained, set look produced by the excessive tension involved in maintaining balance on a two-wheeled machine. 'Bicycle heart' was thought to result from the regular tachycardias of 200-250 that were said to occur during vigorous cycling over a period of many years. 'Cyclist's neurosis' was thought by some to result from the incessant pressure of the bicycle saddle on the nerves of the pelvic floor. As women took to the wheels, great fear was expressed by society in general, and the medical establishment in particular, regarding uterine displacement, distorted pelvic bone, hardened perinea restricting childbirth, and contracted birth canals.

In 1894, the editor of *The Boston Medical and Surgical Journal,* in an article entitled "The Dangers of the Bicycle", said: "It is to be doubted whether such a beneficial exercise will perish because a few imprudent persons with cardiac lesions overdo themselves. . . . There have been too many spindly children built up to healthy vigor, and too many chlorotic, languid girls made rosy and buxom by riding, for physicians to be easily alarmed and dissuaded from believing in 'wheeling'."

Apparently, all health trends elicit disease, which leads ultimately to editorial comment. ❞

Sherman MM: Are exercise ailments cyclical? N Engl J Med 1983; 309:858-859.

Thank Heavens For Little Girls

❝ In her recent note (see 'Is She My Baby Now?', Medical digest, June 1983, p. 1243.), (the author) concludes with the hope that, "with some consciousness raising, there will be more people who would gladly welcome female children".

In recent years, I have asked pregnant women, whose conditions I have routinely evaluated in our adolescent obstetrics clinic, whether they preferred a boy or a girl. The fact that 83 voiced preference for a girl and 58 preferred to have a boy makes me wonder whether (the author) may be too quick to promote a cause, i.e., 'consciousness raising', without sufficient evidence of its effectiveness. As it seems safe to say that the vast majority of lower-social class members in my patient population were not exposed to much consciousness raising, could it be that consciousness raising may have an effect opposite to what she expects?

I also have questions about (the author's) "half-serious" offer to a mother "to adopt and love" the baby about whose sex the mother had mixed feelings. In our study of the reactions of mothers to newborns, we were impressed with the vulnerability of mothers who expressed displeasure with the sex of their children. (Nine of the 49 women spontaneously expressed displeasure. Five of the involved babies were girls and four were boys.) Ordinarily, the mother's displeasure was met with an undue levity and even flippancy—e.g., "should I put him (her) back?"—that made the mothers feel guilty rather than helped them resolve their conflicting feelings. The possibility that these mothers later may have had a great likelihood of difficulties with their babies (i.e., greater incidence of 'colic') offers another example of how physicians might well be more helpful with empathic overtures

rather than moralistic ones that reflect their own highly prized biases when confronted with patients in distress.❞

Carek DJ: Girl babies wanted. JAMA 1983; 250:2603.

Hemorrhage And Vitamin E

❝ (Recent authors) have added another substance to the rapidly growing list of agents reputed to reduce the incidence of periventricular hemorrhage. The data they present must be challenged, as must the relevance of their findings. The hypothesis they put forward hinges on vitamin E reducing the risk of extension of subependymal hemorrhage into the ventricles, and they claim to have shown that it does so. The assumption is made that ultrasound distinguishes pure subependymal hemorrhage from subependymal hemorrhage that has ruptured into the lateral ventricles, a contention I believe to be unjustified. Hemorrhage within the subependymal layer and thrombus within the ventricle are certainly echogenic, but there is no reliable evidence that liquid (unclotted) blood within the ventricles produces echoes; consequently these two types of hemorrhage cannot be separated reliably. A clue to liquid blood in the ventricles during the acute phase of periventricular hemorrhage may lie in degrees of asymmetry between the lateral ventricles due to anechoic liquid blood distending one or other ventricle as is shown in their figure 1b. This they claim to be subependymal hemorrhage (presumably unruptured), but I suggest it is as likely to be intraventricular hemorrhage.

Leaving aside the problem of diagnosis, intraventricular hemorrhage is a common condition, of major importance only if it is associated with subsequent handicap. Parenchymal extension and posthemorrhagic ventricular dilation have both been suggested to be the most important factors predisposing to adverse outcome, but no infant in this study was reported to have had either of these complications, and therefore the question of whether vitamin E prevents major hemorrhage and possible handicap remains unanswered. In addition, there is evidence from Hittner et al. that intraventricular hemorrhage was actually more common in infants receiving vitamin E supplements. In a double blind clinical study of the efficacy of large dose oral vitamin E given early to very low birthweight babies to prevent retrolental fibroplasia, more infants in the treatment group developed intraventricular hemorrhage, and, more specifically, twice as many infants sustained intraparenchymal hemorrhage in the vitamin E group than in the controls.

I understand that the Manchester group now intend to conduct a larger controlled study, and we must await further results before accepting that there is a protective effect of vitamin E against intraventricular hemorrhage.❞

Levene MI: Protective effect of vitamin E against intraventricular hemorrhage in premature babies. Br Med J 1983; 287:617.

Menorrhagia From Nifedipine?

❝ A 46-year-old woman presented with atypical chest pain. Investigations, including coronary angiography, were negative. Nifedipine 10 mg three times daily was prescribed, and previous drugs (thyroxine 0.2 mg daily, bendrofluazide 5 mg daily) were continued. The nifedipine was withdrawn after three weeks because it produced tremor and generalized flushing. The patient's menstrual cycle had previously been regular (5/28 days), but within a week of starting nifedipine she had heavy vaginal bleeding which lasted for five weeks. Thereafter her menstrual cycle returned to normal and remained normal for four months. Nifedipine 10 mg three times daily was then reintroduced; it was withdrawn after one week because it again produced tremors and flushing and because, within a few days, the patient had a recurrence of heavy vaginal bleeding. The bleeding lasted for four weeks. Her menstrual cycle has since returned to normal.

A woman aged 44 presented with atypical chest pain. Results of exercise tests were equivocal. She has been treated with nifedipine 10 mg three times daily. Her menstrual cycle was previously regular (3/28 days), but since she started nifedipine three months ago her periods have been frequent and heavy (5/20 days). Blood count and coagulation screen are normal. Gynecological assessment is planned.

While we have no proof, it seems likely that nifedipine provoked the menorrhagia in these patients. The underlying mechanism may have been local vasodilatation rather than disordered coagulation.❞

Rodger JC, Torrance TC: Can nifedipine provoke menorrhagia? Lancet 1983; 2:460.

Pregnancy Rashes

❝ The pattern of events described by (recent authors) is unfortunately not a rare occurrence. We have examined data for 118 mothers of 119 infants (includes one set of twins) born between July 1978 and 30 June, 1980, registered by the National Congenital Rubella Surveillance Programme as cases of congenital rubella and presumed to have been infected in utero during the 1978-9 epidemic. The information relating to the maternal history and any relevant laboratory-investigations was supplied by the notifying doctor.

In 42 (35%) of the 118 mothers rubella had been confirmed in the laboratory and the pregnancy continued. Another 22 (19%) mothers had no history of illness or contact with rubella during pregnancy. The table shows the history of pregnancy and outcome for the remaining 54 mothers.

There are therefore several lessons to be learnt from these cases. Firstly, a woman who develops or is in contact with a macular or erythematous rash in pregnancy requires full laboratory investigation to exclude rubella. Secondly, finding IgG rubella antibody, whether by hemagglutination inhibition, by single radial hemolysis, or by other techniques, does not indicate *when* the infection occurred. The infection may be very recent and the word "immune", which is sometimes used on reports, is open to misrepresentation. "Antibody present" is perhaps safer. Thirdly, serum specimens from pregnant women who give a history of a recent rash or possible contact

with rubella must be accompanied by full clinical details so that the appropriate laboratory tests may be carried out. Recent infection can be distinguished from past infection by the demonstration of rubella specific IgM antibody. Finally, antenatal screening is *not* a diagnostic test: it identifies those women to whom vaccine should be offered post partum. ❞

Marshall WC, Sheppard S, Stark O, et al: Rash in early pregnancy. Br Med J 1983; 287:609.

Packaging To Prevent Poisoning

❝ The introduction of child resistant containers, and particularly the extension of their use in 1981 to include all solid dose medicines, has been criticized. It is therefore important to determine whether such containers are effective in preventing childhood poisoning. In the absence of any controlled studies we are dependent on retrospective and prospective uncontrolled studies that are riddled with many confounding variables. Dr. G. R. Lawson and colleagues of Newcastle, who have been most prominent in the study of childhood poisoning, have reported their recent findings (in a recent issue). They again show a definite fall in salicylate poisoning after the introduction of child resistant packaging in 1976. Their much quoted original report supported the extension of the use of child resistant containers.

We recently reviewed childhood poisoning in Dundee and also showed a decline in salicylate poisoning, but this decline started in 1970, four years before child resistant packaging was introduced. It is recognized that salicylate has become less fashionable as a simple analgesic and the decreased availability is thought to explain the decline in salicylate self poisoning in adults. The change in availability may also have had some effect on childhood salicylate poisoning and thus influenced the results of a study on this type of poisoning.

The success of child resistant packaging in preventing salicylate poisoning is in strong contrast to its failure to reduce childhood paracetamol poisoning. Dr. Lawson and his colleagues suggest that this failure is due to prescribing paracetamol as an elixir to children. This is not packaged in a child resistant container. They provide no information suggesting that this is the preparation most commonly digested in childhood poisoning. Meredith and his colleagues reported that in the age range one to four years, less than 40% of childhood paracetamol poisonings were from paracetamol elixir, the remainder being from either paracetamol tablets or paracetamol in combination with dextropropoxyphene. Dr. Lawson does not show a decrease in paracetamol poisoning in 1981 when both of these last two preparations were packaged in child resistant containers. In contrast to salicylate there has been a steady increase in the purchase and prescribing of paracetamol and this greater availability may have counteracted the effects on paracetamol poisoning of child resistant packaging.

Dr. Lawson's data show that the total number of poisoning episodes has declined during the study period. Unfortunately, he does not break these figures down into medicinal and non-medicinal poisoning, but the text suggests that this decline is predominantly in the medicinal group. We have similar data for Dundee, showing a steady decline in admissions after childhood poisoning, the decline being greatest for ingestion of medicines, with no pronounced trend in non-medicinal poisoning. Such a decrease was shown for medicines that were packaged in child resistant containers and also for benzodiazepines, tricyclic drugs, and barbiturates, which were not packaged in child resistant containers. Unlike the Newcastle group, we think that the previous preventive measures, such as publicity campaigns emphasizing the need for care in handling and storing medicines, suitable warnings on labels of all medicines, and the suggestion to return all unused medicines, have made the general public more aware of the risk of childhood poisoning.

We agree with Dr. Lawson that medical practitioners should always be aware of the risk of childhood poisoning and take care in prescribing. We found in Dundee that there was an increase in medicinal poisoning in single parent households. We found that 43% of the drugs ingested by children in such households were anxiolytic, hypnotic, and antidepressant drugs, and 50% of all diazepam ingestions took place in families where there was a single parent. Prescribing such medicines to a harassed single parent is common practice but is undesirable as it does not solve the underlying problem; it simply makes the parent less aware of his or her surroundings and less alert to the danger of an inquisitive child swallowing the medicine. ❞

Forsyth JS, Hayman ME: Changing pattern of poisoning in children. Br Med J 1983; 287:496.

Perioral Dermatitis

❝ Perioral dermatitis usually affects women between the ages of 20 and 40 years. Lesions consist of papules and pustules grouped around the mouth and on the chin . . . , although typically the skin around the lips is unaffected.

The distribution of lesions, and the absence of comedones, distinguishes perioral dermatitis from acne vulgaris.

Patients should be given oral tetracycline 250 mg twice daily. The treatment should continue for six to 12 weeks, followed by a second course if necessary. Alternative antibiotics in-

clude erythromycin and co-trimoxazole.

It is possible that many cases of perioral dermatitis may have been aggravated by the use of topical fluorinated corticosteroids, in which case this treatment should be stopped. The rash may flare when corticosteroids are discontinued. Patients should be warned about this possibility, and a weak corticosteroid (one percent hydrocortisone) may be used for the first one or two weeks of treatment. ❞

Hay R: The aggravation of perioral dermatitis. Mims 1983 Sept 15; p 60.

Problem Pts.—Or Problem Doctors?

❝ (Recent authors) identified certain 'problem' patients whom doctors sometimes do not understand and whom they often offend; this was a noteworthy effort to provide some islands of specificity in the uncharted swamps of humanistic epistemology. I would add that most patients offended by physicians are not 'problem' patients. They are just ordinary, everyday patients.

Many of the offenses to the sensibilities of patients arise from laziness, thoughtlessness, and the bad manners of physicians. There is nothing new about this; it is illustrated in the descriptions of the haughty, cane-swinging dandies who were among the physicians of eighteenth-century London.

What are some of the things that bother patients so much? First of all, waiting unnecessarily in the office. The physician need only take his own time and effort to make more realistic appointments. Then, there is offense if the physician goes off on a trip without warning his critically ill patients or their anxious families; a severe reaction will arise if the departing physician says that Dr. Doe is covering and the patient discovers only belatedly that Dr. Doe has no idea that he is covering anything. And there is the matter of the physician who will not sit down and talk with the patient realistically about plans, hopes, and problems, free of a standing audience of white-clad sycophants in the old (I hope, abandoned) 'ward rounds' routine.

Among the most notable of the irritations to the public is the hiding of physicians: an unlisted telephone number is a severe trial to patients. Many pediatricians and many health-maintenance organizations have a call-in hour during which patients are encouraged to call. This is a good example for others to follow. Are we now reaching a time, the house call having vanished, when the call to the house is equally difficult?

Many of these little habits and customs are matters that are set straight by ordinary good manners, friendliness, politeness, and willingness to be heckled a little in return for the inestimable privilege of being a physician. Most patients would list these matters under the heading of 'humanism'. ❞

Moore FD: Teaching humanistic medicine. N Engl J Med 1983; 309:860.

Reaction to IV Iron

❝ We report here a severe reaction to intravenous iron dextran and draw attention to the dangers of this form of treatment when the limited indications for its use are not closely observed.

The patient was a 29-year-old primigravida who was found to have a hemoglobin of 10.3 g/dl at 32 weeks' gestation. Mean cell volume 95 fl, mean cell Hb33.1 pg; mean cell Hb concentrate 33.7 g/dl, serum folate 11.3 ng/ml (normal 1.8-14), red cell folate 753 ng/ml (125-800), and serum vitamin B_{12} 149 ng/l (170-940). The serum B_{12} two weeks post-delivery was 337 ng/l with a normal Schilling test. The serum ferritin was 28 ng/l (10-150 μgl) and the blood film showed no red cell changes of iron deficiency.

Despite these results, she was admitted to the obstetric unit and 32 ml iron dextran ('Imferon') was administered intravenously. The dose was calculated from the manufacturer's formula given on the data sheet. The infusion was uneventful and the patient was allowed home the same day.

Twenty-four hours later she had muscle cramps and bilateral frontal headaches, side-effects mentioned by Fison's in their September, 1982, pharmaceutical circular. Over the next two hours the headaches became increasingly severe and neck stiffness developed. On readmission to hospital she had become markedly opisthotonic with photophobia. She was apyrexial and there was no papilloedema. She remained alert and orientated throughout and no focal neurological signs were elicited.

Lumbar puncture revealed clear, colorless CSF under normal pressure: white cells 3/μl, red cells 1/μl, protein 900 mg/l. Bacterial and viral cultures were negative. Her CSF iron was very high at 36 μmol/l (normal 1-3).

Over the next few days her symptoms gradually subsided and she was discharged with no neurological sequelae. The hemoglobin level did not rise after the infusion of iron and there is no doubt her low Hb was not due to iron deficiency.

We believe that the exceptionally high CSF iron level was responsible for her meningitic symptoms, a previously unreported complication of iron dextran therapy. The situation was made worse by the absence of iron deficiency which resulted in abnormally high levels of free iron which was able to cross into the CSF.

Intravenous iron therapy should be used with care. ❞

Shuttleworth D, Spence C, Slade R: Meningism due to intravenous iron dextran. Lancet 1983; 2:453.

Sniffing Out Sarcoidosis

❝ . . . Sarcoidosis may impair olfactory or gustatory function by three mechanisms: direct invasion of the olfactory bulb and tract by meningeal granulomas, obstructive nasal-mucosal granulomas, or peripheral facial-nerve paresis with involvement of the chorda tympani branch.

The potential dangers of impaired taste and smell . . . were demonstrated in one of my patients with sarcoidosis. She had two experiences in which household stove gas escaped, without her being able to smell it; on one of these occasions, a minor explosion occurred. Her family also related that she had unknowingly served spoiled food to them on several occasions. Because patients with sarcoidosis may initially present with impairments in taste and smell only and because steroid therapy is often helpful, awareness of these sensory problems is important. ❞

Delaney P: Taste and smell in disease. N Engl J Med 1983; 309:1062.

A Spacey Infant 'Burp' Sign

"(Recent correspondents) deserve congratulations on their use of the succussion splash as an infant 'burp' sign (see Burping baby, Medical digest, October 1983, p. 1990.). This sign may save harried parents countless hours of trying to 'burp' their crying child when in fact no burp could possibly be forthcoming. It could also redirect their efforts to more appropriate therapy.

About 13 years ago, we also discovered a useful sign that served us well with each of our three children. We found that tympany of Traube's space would disappear in the child after we successfully induced a burp. Like the succussion splash, this suggested that the air in the stomach had disappeared. Traube's space is bound medially by the left edge of the liver, laterally by the medial edge of the spleen, and superiorly by the lower border of the heart. The advantage of this sign over the succussion splash is that it does not require the vigorous shaking of a crying infant. A negative succussion-splash sign leaves one in doubt about whether the infant has indeed been jiggled sufficiently. It is relatively easy, however, for a trained person to determine whether Traube's space is tympanitic or dull."

Zidulka J, Zidulka A: Tympany in Traube's space as an infant 'burp' sign. N Engl J Med 1983; 309:859.

Autopsy Rates: 'Good' . . .

"What is a 'good' autopsy rate? On the one hand, I reject on a cost basis the position that everyone who dies needs an autopsy ($750-$1,000 per autopsy of two to three million deaths per year in the United States). On the other hand, I reject the position that there should be no autopsies. Instead, I believe that the goal or goals of an autopsy need to be defined before an autopsy rate becomes meaningful. Some possible goals include assessment of the quality of the clinicians, evaluation of a noninvasive test or a therapy, acquisition of information for counselling survivors, acquisition of evidence for a criminal investigation, or creation of a data base that someone might someday use. For example, if evaluating the quality of the clinician is the goal, a random sample (no refusal allowed) of five to ten percent of all deaths would probably be sufficient. However, if one were evaluating a noninvasive test, any rate less than 100% would increase both morbidity and cost. I believe that it is time that each autopsy should be looked at in terms of what one hopes to learn, what the chances are of learning it, and what it costs, as we should view other tests, procedures, and therapies. It is time that the dogma that everyone who dies or who dies in a teaching institution needs an autopsy should be discarded, because it is neither good medicine nor good education."

Wells RJ: The value of the autopsy. N Engl J Med 1983; 309:732-733.

. . . And 'Bad'

"In addition to the fact that autopsies help physicians appreciate persistent shortcomings in the current art of clinical diagnosis, the post-mortem examination makes available invaluable donor tissue for research. Tissue is the critical resource for numerous innovative research protocols directed toward the study of a large group of incurable diseases that continue to stymie medical science as they exact their price in suffering and death.

Recognizing the inherent limitations of clinical trials and of animals as experimental models for human illnesses, the National Institutes of Health and other public and private agencies fund a number of human-tissue banks. These banks rely entirely on a steady rate of autopsies performed, with the consent of the family, on patients who have had a thorough medical workup, to obtain a wide range of tissue samples. Three major neurologic-research banks (based in Los Angeles, Boston, and Washington, DC.) acquire and distribute brain and other neural and non-neural autopsy specimens to scientists throughout the United States. They, in turn, perform a remarkable spectrum of sophisticated techniques to search for immunologic, virologic, biochemical, toxicologic, and genetic clues to the understanding of multiple sclerosis, Alzheimer's disease, Parkinson's disease, Huntington's disease, amyotrophic lateral sclerosis, schizophrenia, manic depression, and many other neurologic and psychiatric disorders. A Philadelphia-based tissue bank for diabetes research provides investigators with specimens from the pancreas and from various organs affected by the development of this disease.

The present low rate of autopsies seriously curtails the ability of our tissue banks to satisfy the dramatically expanding need for fresh, fresh-frozen, and formalized research specimens."

Tourtellotte WW, Berman KE: The value of the autopsy. N Engl J Med 1983; 309:733.

Answer to Dermacase (page 2301)

4. Cutis laxa

Cutis laxa (generalized elastolysis) is a rare disorder. Early in life, frequently at birth, the skin begins to sag and hang in pendulous folds. The hanging of facial and eyelid skin results in a 'bloodhound' or aged appearance. Systemic manifestations include pulmonary emphysema, ventral, hiatal and inguinal hernias, diverticulae of the gastrointestinal tract and urinary bladder and pulmonary emphysema. The disease may gradually progress with a pulmonary death possible between the ages of 20 and 40. In this disease there appears to be an increased destruction of elastic fibers by elastase. There is no effective treatment.

The only disease with which curtis laxa might be confused is one of the forms of Ehlers-Danlos syndrome. In Ehlers-Danlos syndrome, the skin is extensible but springs back into place when released. Hyperextensible joints, and pseudotumors of the skin with atrophic scars, are seen in Ehlers-Danlos but not in cutis laxa.

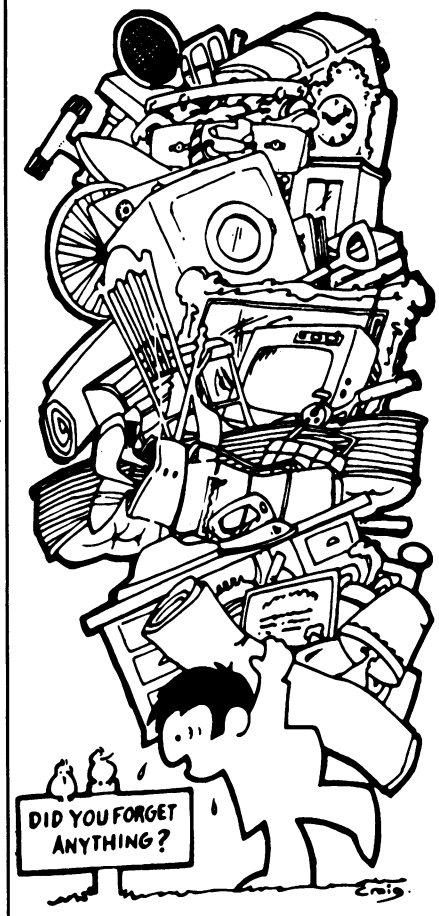
Canadian Family Physician

Annual Subject and Author Index, Vol. 29

This index is listed first according to subject and then according to author. In the subject index, articles are listed by page number. Subjects which appeared as letters, editorials, news, lifestyle news or comment items are coded L, E, N, LN and C respectively. The author's index provides the author's name, the article's full title, and the page number.

Subject Index

Author Index



Change of Address

If you plan to move, please let us know well in advance by attaching the address label from your copy of the journal in the space provided and by filling in your new address.

If you're a family physician and are not getting your own copy of the journal, let us know.

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5th COLUMN

Seen any good misprints lately? Heard any good lines from patients? We're interested—a laugh a day keeps the doctor away. Send items to The Fifth Columnist, 4000 Leslie St., Willowdale M2K 2R9.

A Tall Tale

"A ghost-like figure which resembled a giraffe and carried a handbag scared two women out of their wits when it loomed in front of their car on a Karoo road in broad daylight this week."

Johannesburg Sunday Times

I Can't See It Happening

"To many a car owner, there is nothing more frustrating than to return to his parked car and find it stolen".

Times of Malta

. . . except maybe not finding it at all.

Sounds Fishy

Britain's *Evesham Journal* recently recounted the case of an unwary motorist who "reversed his lorry away from a vehicle parked in front and bumped a carp parked close behind, which was unnoticed".

Bet that incident troubled his sole!

Sign of the Times

"Mr. Roberts went to the Deeside Enterprise Trust, a body aiming to introduce unemployment in the area and throughout the country."

Wrexham Evening Leader

They must have plenty of business these days.

Sporting Doc

Seems people will steal anything these days. A newspaper reported that "A doctor's white coat containing several pieces of medical equipment was stolen from the nurses' home at Yarmouth's Northgate Hospital early on Sunday. The items stolen included a stethoscope, an ophthalmascope, a patella hammer, and a set of darts."

Eastern Daily Press

No need to wonder what the 'point' of the robbery was.

If You Say So

"Develop interpersonal conversation skills by learning to talk good."

Advertisment in the San Mateo (California) Times

You mean even gooder than what we talks now?

Friendship Fiasco

Good Neighbors' Day they called it. It was a charity, fundraising event in London, England . . . where live all those cheerful cockneys and stiff-necked, but courteous, city gents. But something went sadly wrong. According to the *Houston Chronicle, six people were hospitalized after a fight broke out among 150 'good neighbors'*.

Right Proud

Seen in a doctor's office. Right up there on the wall, amongst his medical degrees and diplomas, the doctor had hung a framed certificate for exemplary penmanship in the eighth grade.

I guess he read the writing on the wall.

Thinking Big

Spotted on a university campus, a proud young student wearing a t-shirt emblazoned with the words "I am going to be a doctor". Spotted on the back of the bike he was riding, "I am going to be a Mercedes".

Obviously he had a lot of drive!